MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
BUREAU OF NUTRITION SERVICES AND WIC

WIC CERTIFICATION - WOMEN

Persons with disabilities who require alternative means for communication of program information (Braille, large print, audiotape, etc.) may contact the Missouri Department of Health and Senior Services, Bureau of Nutrition Services and WIC, phone 1-800-392-8209. TDD users can access the previous phone number by calling 1-800-735-2966. An equal opportunity provider and employer.

AGENCY ☐ ADDITION ☐ RECERT

SCLR

DCN | LAST NAME | SUFFIX | FIRST | MIDDLE | MAIDEN

RACE (1 - WHITE, 2 - BLACK/AFRICAN AMER., 4 - AM. IND./ALASKAN, 5 - ASIAN, 6 - NATIVE HAW/PAC ISL, U - UNABLE TO DETERMINE) | ETHN HISP Y N U | BIRTHDATE | SOCIAL SECURITY NUMBER

COMMON DATA SYSTEM ID 02

H201 ADD H202 UPDATE

MARITAL STATUS (CIRCLE) S M W D SEP DECL | PRESENTLY EMPLOYED Y N U | TEMP MEDICAID T | FOOD STAMPS Y N U | FOSTER CARE Y N

STREET ADDRESS | CITY | STATE MO | ZIP CODE

PHONE ( ) | MESSAGE PHONE ( ) | PARTICIPANT EDUCATIONAL LEVEL | COUNTY OF RESIDENCE

HEALTH HISTORY

H204 ADD H205 UPDATE

LAST NML. MENSES DATE | PRIOR DEL. DATE | MO PRENATAL CARE BEGAN | PRE PREGNANCY HEIGHT /8 IN /10CM | PRE PREGNANCY WEIGHT LBS KG

GRAVIDITY | TERM | PRETERM | SPON/IND ABORT | FETAL DEATH | CHILDREN LIVING (AT BIRTH)

SMOKING CHANGES DURING PREGNANCY?

SMOKING/DRINKING BEHAVIOR 3 MONTHS PRIOR TO PREGNANCY
1. AVE # OF CIGARETTES SMOKED/DAY?
2. AVE # DAYS/WK HAD ALCOHOLIC DRINK?
3. AVE # ALCOHOLIC DRINKS ON DAYS HAD A DRINK?
4. OTHERS IN HOUSEHOLD THAT SMOKE? Y N U

OUTCOME DATA ALL BREASTFEEDING & NON-BREASTFEEDING (DO NOT COMPLETE FOR PRENATAL)

H210 ADD H211 UPDATE

DELIVERY DATE | DELIVERY TYPE V C | PREG. WT. GAIN/LOSS IN LBS. + / – | (0-97) 98 (≥98) 99 (UNK) | FOOD STAMPS Y N U | OUTCOME IF: FD SA

DIABETES: Y N U | ONLY W/CURRENT PREGNANCY Y N | HIGH BLOOD PRESSURE Y N U | ONLY W/CURRENT PREGNANCY Y N

SMOKING CHANGES SINCE DELIVERY?

SMOKING/DRINKING BEHAVIOR DURING LAST 3 MONTHS OF PREGNANCY
1. AVE # OF CIGARETTES SMOKED/DAY?
2. AVE # DAYS/WK HAD ALCOHOLIC DRINK?
3. AVE # ALCOHOLIC DRINKS ON DAYS HAD A DRINK?
4. OTHERS IN HOUSEHOLD THAT SMOKE? Y N U

WIC ELIGIBILITY CLIENT DATA

CAPE SITE | PROG. P B N | MIGRANT M | SPECIAL STATUS H T O | CONTACT DATE | TYPE OF CONTACT T W | FAM. SIZE | FAMILY INCOME W M A $ | FIN. ELG. Y N A X

H402 RECERT H407 INQUIRY

SMOKING/DRINKING BEHAVIOR IN LAST 7 DAYS
1. AVE # OF CIGS SMOKED/DAY?
2. AVE # DAYS/WK HAD ALCOHOLIC DRINK?
3. AVE # ALCOHOLIC DRINKS ON DAYS HAD A DRINK?

SEEING PHY. Y N | DIET ASSESS. Y N | EDC | PLAN BF Y N U | HEIGHT /8 IN /10CM | WEIGHT /4 LBS /10 KG | HLTH ASSESSMT DATE

H401 ADD H403 UPDATE

HEMATOCRIT /10 | HEMOGLOBIN /10 | BLOODWORK DATE | ORAL ASST. Y N | MED ELIG Y C M | RISK FACTORS | PRIORITY | FOOD PKG. | SEQ. | CYCLE 1 2

SERVICE DATE | RECERT. DATE | BMI | CPA INIT. | NEW FPC | NEW SEQ. | NEW CYCLE

REFER TO (CIRCLE): IMMUN SHCN | PHY SUB ABUSE | DNTL HLTH LEAD | TANF EXTEN | FD STAMPS COM BASED | MCAID OTHER | FAM PLN NO REFERRAL | SCH HLTH

SIGNATURE (INCOME ASSESSMENT) ▶ | TITLE | DATE

SIGNATURE - CPA (RISK ASSESSMENT) ▶ | TITLE | DATE

Delivery Date Mo. Yr.	Birth Weight Lbs. Oz.	Problems

PARTICIPANT'S RIGHTS AND RESPONSIBILITIES

READ BY OR READ TO THE PARTICIPANT AT THE TIME OF CERTIFICATION.

1. VERIFICATION OF INCOME IS DETERMINED BASED ON INFORMATION REPORTED BY YOU AND ASSESSED ACCORDING TO CURRENT INCOME GUIDELINES PROVIDED BY THE STATE AGENCY.
2. STANDARDS FOR ELIGIBILITY AND PARTICIPATION IN THE WIC PROGRAM ARE THE SAME FOR EVERYONE REGARDLESS OF RACE, COLOR, NATIONAL ORIGIN, AGE OR DISABILITY.
3. YOU HAVE THE OPPORTUNITY TO APPEAL ANY DECISION MADE BY THIS LOCAL AGENCY REGARDING YOUR ELIGIBILITY FOR THE WIC PROGRAM.
4. THIS LOCAL AGENCY WILL MAKE HEALTH SERVICES AVAILABLE TO WIC PROGRAM PARTICIPANTS. YOU ARE ENCOURAGED TO PARTICIPATE IN THESE HEALTH SERVICES.
5. YOU MUST NOTIFY THIS LOCAL AGENCY BEFORE MOVING TO MAINTAIN UNINTERRUPTED PROGRAM BENEFITS.

THIS CERTIFICATION IS BEING MADE IN CONNECTION WITH THE RECEIPT OF FEDERAL FUNDS. PROGRAM OFFICIALS MAY VERIFY INFORMATION ON THIS FORM. INTENTIONALLY MAKING A FALSE OR MISLEADING STATEMENT OR INTENTIONALLY MISREPRESENTING, CONCEALING OR WITHHOLDING FACTS MAY RESULT IN PAYING THE STATE AGENCY, IN CASH, THE VALUE OF THE FOOD BENEFITS IMPROPERLY ISSUED AND MAY SUBJECT YOU TO CIVIL OR CRIMINAL PROSECUTION UNDER STATE AND FEDERAL LAW.

I HAVE BEEN ADVISED OF MY RIGHTS AND OBLIGATIONS UNDER THE WIC PROGRAM. I CERTIFY THAT THE INFORMATION I HAVE PROVIDED FOR MY ELIGIBILITY DETERMINATION IS CORRECT TO THE BEST OF MY KNOWLEDGE.

I consent to the release of necessary and required program information on myself and/or my children to the Food and Nutrition Services administered by United States Department of Agriculture; Maternal and Child Health Programs (Dental Health, Children with Special Health Care Needs, Immunization, and Family Planning programs) administered by Missouri Department of Health and Senior Services; Head Start, Migrant Education Programs administered by Missouri Department of Elementary and Secondary Education; and Medicaid administered by Missouri Department of Social Services for the purpose of determining eligibility, and conducting outreach activities.

DATE | SIGNATURE OF PARTICIPANT/PARENT/GUARDIAN ▶